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SCHOOL AGE CHILD HISTORY

Please fill out this form carefully and bring it with you to your appointment.

A. GENERAL INFORMATION

Child's full name _____ Present age _____ Birth date _____
 Name and address of school _____

 Grade _____ Teacher _____ School Nurse _____ Principal _____
 Is your child especially afraid of doctors? Yes No Child's handedness: Right Left
 Referred by: _____

A. FAMILY

Father _____ Birth date _____
 Mother _____ Birth date _____
 Brothers _____ Birth date _____
 & _____ Birth date _____
 Sisters _____ Birth date _____

B. PARENT INFORMATION

Home address _____ City _____ State ____ Zip _____
 Occupation _____ Home Phone _____
 Email _____ Fax Number _____
 Mother Employer _____ Business Phone _____
 Business address _____ City _____ State ____ Zip _____
 Father Employer _____ Business Phone _____
 Business address _____ City _____ State ____ Zip _____
 Do you have Major Medical Insurance? Yes No
 If so, what is the carrier? _____ Policy # _____

C. MEDICAL HISTORY

Child's most recent medical examination: _____
 Doctor's name _____ Date _____
 Results _____
 Medications currently using: _____ For what condition: _____

Any history of the following in your family? Diabetes Glaucoma High Blood Pressure

Has your child been diagnosed as having any of the following?

Learning Disabilities Developmental delays ADD or ADHD Cerebral Palsy
 Seizure disorders Autism Other _____

List illnesses, bad falls, head injuries, high fevers, etc.

Is your child generally healthy? Yes No
Are there any chronic problems like asthma, hay fever, allergies? Yes No If so, please list: _____

Has a Neurological Evaluation been performed? Yes No By whom? _____
Results? _____

Has a Psychological Evaluation been performed? Yes No By whom? _____
Results? _____

Does your child currently receive:
 Occupational therapy services? By Whom? _____
Results? _____

Physical therapy services? By Whom? _____
Results? _____

Speech therapy services? By Whom? _____
Results? _____

Other therapy services? By Whom? _____
Results? _____

D. NUTRITIONAL INFORMATION

Current diet: Excellent Good Fair Poor
Does your child like or crave sweets? Yes No
Is your child active? Not active Moderately active Extremely active
Are there periods of very high energy? Yes No low energy? Yes No

E. DEVELOPMENTAL HISTORY

Full term pregnancy? Yes No Normal birth? Yes No
Any complications before, during, or immediately following delivery? _____

Did your child crawl (stomach on floor)? Yes No Age? _____
creep (stomach off floor)? Yes No Age? _____
move on all fours? Yes No If not, please describe _____

At what age did your child walk? _____ Was child active? Yes No

Speech: First words at age _____ Was speech clear to others? _____
Is it clear now? Yes No Explain: _____

Any history of crossing eyes? Yes No What age first noticed? _____
Any family history of crossing eyes? Yes No Who? _____

F. VISUAL HISTORY

Child's most recent vision examination: _____
Doctor's name _____ Date _____
Results _____

Reason for examination: _____
Were glasses prescribed? Yes No Are they worn? Yes No When? _____

Members of the family who have had visual attention and why:

Name	Age	Visual Situation
_____	_____	_____
_____	_____	_____
_____	_____	_____

G. PRESENT SITUATION

Is there any evidence from the school or psychological tests that some visual malfunction may be present? Yes No

If so, what _____

Does your child report any of the following?

- Headaches Yes No When? _____
- Blurred vision Yes No When? _____
- Double vision Yes No When? _____
- Eyes "hurt" or "tired" Yes No When? _____

List any other complaints your child makes concerning his/her vision. _____

Have you ever noticed the following?	Yes	No	If so, when?
Eye frequently reddened	<input type="radio"/>	<input type="radio"/>	_____
Frequent eye rubbing	<input type="radio"/>	<input type="radio"/>	_____
Frequent blinking	<input type="radio"/>	<input type="radio"/>	_____
Head close to paper when reading or writing	<input type="radio"/>	<input type="radio"/>	_____
Tilting head when reading	<input type="radio"/>	<input type="radio"/>	_____
Tilting head when writing	<input type="radio"/>	<input type="radio"/>	_____
Moves head when reading	<input type="radio"/>	<input type="radio"/>	_____
Confuses letters or words	<input type="radio"/>	<input type="radio"/>	_____
Reverses letters or words	<input type="radio"/>	<input type="radio"/>	_____
Skips, rereads, or omits words	<input type="radio"/>	<input type="radio"/>	_____
Vocalizes when reading silently	<input type="radio"/>	<input type="radio"/>	_____
Reads slowly	<input type="radio"/>	<input type="radio"/>	_____
Uses finger as marker	<input type="radio"/>	<input type="radio"/>	_____
Poor reading comprehension	<input type="radio"/>	<input type="radio"/>	_____
Writes or prints poorly	<input type="radio"/>	<input type="radio"/>	_____
Tires easily	<input type="radio"/>	<input type="radio"/>	_____
Avoids near tasks	<input type="radio"/>	<input type="radio"/>	_____
Short attention spans	<input type="radio"/>	<input type="radio"/>	_____
Poor motor coordination	<input type="radio"/>	<input type="radio"/>	_____
Difficulty hitting/catching ball	<input type="radio"/>	<input type="radio"/>	_____
Television viewing	How much _____	How often _____	Viewing Distance _____

H. SCHOOL

Age at time of entrance to: Kindergarten _____ First grade _____

Does child like school? Yes No Teacher? Yes No

School work is: Above Average Average Below Average

Do you feel that (s)he is working up to potential? Yes No

Does the teacher feel that (s)he is working up to potential? Yes No

What school subjects come easy for child? _____

Does child like to read? Yes No Voluntarily? Yes No What? _____

Specifically describe any school difficulties: _____

Has a grade been repeated? Yes No Which? _____

Has (s)he changed schools often? Yes No When? _____

Does (s)he seem to be under tension or extreme pressure when doing school work? Yes No

Explain: _____

Has (s)he had any special tutoring and/or remedial assistance? Yes No How long? _____

When? _____ From Whom? _____

Results? _____

What is the child's attitude toward reading, school, his/her teachers, other youngsters? _____

How well developed is his/her spoken vocabulary? _____

I. GENERAL BEHAVIOR

Are there any behavior problems? School Yes No Home Yes No

What causes these problems? _____

Child's reaction to fatigue? Sag Irritable Other _____

Child's reaction to tension? Nail biting Thumb sucking Other _____

Does (s)he say and/or do things impulsively? Yes No In constant motion? Yes No

Can the child stay still for long periods of time? Yes No

B. FAMILY AND HOME

Please indicate which adults the child lives with: Mother Father Step Mother Step Father Aunt
 Uncle Grandmother Grandfather Adoptive Parents Foster Parents Other

Has (s)he been through a traumatic family situation?(Such as divorce, parental loss, separation, severe parental illness) Yes No

What age was the child when this situation occurred? _____ Has the child adjusted? Yes No

Is family life stable at this time? Yes No

How does (s)he get along with:

Parents? _____

Siblings? _____

Classmates in school? _____

Playmates at home? _____

Did father or anyone in father's family have a learning problem? Yes No If so, who? _____

If so, who? _____ Explain _____

Did mother or anyone in mother's family have a learning problem? Yes No If so, who? _____

If so, who? _____ Explain _____

Is there any history of mental retardation, psychological disturbance, etc. on either side of the family? Yes No

If so, who? _____ Explain _____

Any of the other children in the family have a history of learning problems? Yes No

If so, who? _____ Explain _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

J. REPORT POLICIES

Would you like copies of any reports? Yes No Would you like copies of any reports sent to anyone else? If so, please list name and address. _____

Please sign below to give us permission to release information about your child to the above sources. (Valid for 90 days only)

Signed _____

Date _____